Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HOUSTON HOSPITAL FOR SPECIALIZED SURGRY

Respondent Name
SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number
M4-14-0545-01

Carrier's Austin Representative
Box Number: 01

MFDR Date Received
October 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[Injured employee] an employee of Commercial Fence received treatment that were agreed to be the result of a work related injury on 10/30/12. While checking claim status on other claims were informed on 7/8/13 that this claim was never received by Service Lloyds Insurance. The claim was billed on 11/5/12 to the employer, Commercial Fence. I spoke to Dorian at Commercial Fence on 7/8/13 and he didn't know what happened to the claim when it was mailed to the employer's address of 2833 Westside Dr. Pasadena, TX 77502."

Amount in Dispute: $38,507.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Labor Code §408.027(A) states, 'A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injury employee. Failure by the health care provider to timely submit a claim for payment constitutes a **forfeiture of the provider's right to reimbursement** for that claim for payment.' The Requestor alleges this bill was first mailed to the Employer on November 5, 2012. The Employer should not receive any billing unless such an arrangement has been requested by the Employer. The Requestor has submitted no proof showing such an arrangement was put in place..."

Response Submitted by: WHITE ESPEY PLLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 30, 2012	Hospital Outpatient Services – CPT Codes 26037, 26418, 26785, 35207 and 69990	$38,507.09	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. Per 28 Texas Administrative Code §133.20(j)(1)(C), a health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the right to medical dispute resolution as provided by Labor Code §413.031. Review of the submitted information finds that the requestor submitted the medical bills for the services in dispute to the injured worker's employer. The Division therefore concludes that the requestor has waived the right to medical fee dispute resolution.

Conclusion

The requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the medical fee issues have not been addressed. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 20, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.